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BEFORE THE STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION

JULY 7, 2004

I am Jack Hoadley, a Research Professor at the Health Policy Institute of Georgetown University, and I am happy to have this opportunity to appear before the Commission.

Along with several colleagues, I received a grant from the Robert Wood Johnson Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative to conduct a study on the experience of state pharmaceutical assistance programs. In this project, we are conducting case studies in fourteen states that have had active pharmaceutical assistance programs for seniors in place for at least two years and have a minimum of 5,000 enrollees. We are gathering information on operational concerns such as coordination of benefits, communicating with enrollees, administering eligibility and cost sharing, and approaches to managing drug costs. In addition, we are examining the plans states are considering to modify their programs in response to the new Medicare discount card and Part D drug benefit. In each state, the team is conducting semi-structured interviews with key state officials, pharmacy benefit managers, and representatives of pharmacies, physicians, and beneficiaries.

We are currently in the field conducting interviews, so we do not have conclusive findings. But we did want to share a few initial observations and insights about the way state programs have been working with the new Medicare discount card.

1. Several states are using auto-enrollment procedures to get cards for enrollees, especially those who qualify for the $600 transitional assistance.

2. Most states that are using auto-enrollment are selecting a single card, generally one offered by a sponsor with an existing affiliation with their program. At least one state is offering multiple cards for its auto-enrollment program.

3. For programs that offer extensive benefits, the savings are mostly accrued by the states, providing opportunities to use the proceeds either to reduce state expenditures or to enhance the program. Beneficiaries qualifying for transitional may achieve small savings in the form of reduced cost sharing.

4. For other programs, particularly those covering only certain drug classes, there are more significant savings available to beneficiaries who enroll in transitional assistance.

5. For any state program that has at least some enrollees who obtain discount cards, there are new coordination of benefits issues, for example, how to make sure the transitional assistance value is drawn down before state funds are used.

Although it is early to draw any certain conclusions, we think there are lessons for the Medicare Part D benefit from this experience with the discount card.

1. State programs and CMS are gaining experience working together in the discount card program and -- to their mutual benefit -- are learning more about each other.

2. Unlike the discount card, the Part D benefit will affect all state program enrollees, not just the subset of enrollees, such as those who qualify for transitional assistance. Furthermore, all state programs will be affected, including those operating under Medicaid waivers whose members are not eligible for discount cards.

3. Some states have experience with coordination of benefits, and some have devoted considerable resources to coordinating their coverage with other arrangements. Other state programs limit eligibility to individuals with no other source of coverage and thus have little or no experience with coordination of benefits. For some, the discount card will offer some additional experience.

4. Those beneficiaries for whom state programs today provide a single source of drug coverage may under Part D have two sources of coverage and face the need to coordinate between a private drug plan and the state program. Beneficiaries in other state programs, where current coverage has gaps, may find they are able to fill some of those gaps.

5. States wishing to use savings for expanded coverage have significant opportunities, but also face challenges in deciding whether to move coverage up the income scale, add classes of drugs previously not covered, or add disabled beneficiaries to their programs. Other states may choose to apply the savings to other priorities -- or even eliminate their programs altogether. All of these policy decisions have the potential to raise complex political issues in their states.

6. Regardless of how programs change, a massive communications job will be necessary to help program participants understand the changes that will come in 2006, especially if auto-enrollment is not possible under the Part D benefit. State programs will try to draw on experience with changes in eligibility or cost-sharing arrangements to identify effective communication strategies.

We hope these observations provide some ideas to contemplate. As we complete our case studies over the next few months, we expect to modify and expand these findings and conclusions, and we hope to have the chance to share further findings with the Commission at a later meeting. Furthermore, if there are areas of special interest to the Commission where we can focus some attention as we continue our data collection, we hope you will feel welcome to call upon us.

Again, thank you for this opportunity to appear.